Bureau of Health Care Quality & Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVS4985AGZ | A. BUILDING _____ B. WING _____ | 08/29/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **STACEY RESIDENTIAL CARE** | **5329 STACY AVENUE LAS VEGAS, NV 89108** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Y 000 | Initial Comments<br><br>This Statement of Deficiencies was generated as a result of the initial state licensure survey conducted in your facility on August 29, 2008.<br><br>The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.<br><br>The facility was licensed for 10 total beds.<br><br>The facility had the following category of classified beds: Category 2 - 10 beds.<br><br>The facility had the following endorsements: Residential facility which provides care to persons with Alzheimer's disease<br><br>The census at the time of the survey was zero. One mock resident file was reviewed and one employee file was reviewed.<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.<br><br>The facility was found to be in compliance with the regulations regarding this survey. No further action is necessary concerning this report. Please retain this copy for your records. | Y 000 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE